

**Troy Community Consolidated School District 30-C
Will County, Illinois**

Student: _____ Birthdate: _____ Grade: _____

ADMINISTRATION OF MEDICATION AT SCHOOL

When a child requires prescription medication for his/her CRITICAL HEALTH, the primary responsibility for administering such medication rest solely upon the parent, guardian, designated adult, or the student. For those instances in which the doctor has determined that medication during school hours is necessary for the CRITICAL HEALTH of the child, the school district will adhere to the following:

1. Medication is defined as REGISTERED prescription drugs, or over the counter medicine.
2. The physician will complete the "Order of Medication" form (below).
3. The parent/guardian will complete the "Designee to Administer Medication" form (below).
4. Medication will be stored in the school office in its original container. (It is highly recommended that inhalers, or additional inhalers, are also stored in the school office.)
5. For students who must carry inhalers on their person ...
 - a. Parents must complete "Parent/Guardian Consent for Student's Self-Administration of Asthma Medication"(reverse side of sheet).
 - b. Parents and student must complete "Agreement of Student and Parent Regarding Use of an Asthma Inhaler in School" (reverse side of sheet).
6. Please note that no school district employee shall administer medication to the student.
7. Permission for the self-administration of medication is effective for the school year for which it was granted. It must be renewed each school year.
8. A RESPONSIBLE ADULT MUST DELIVER THE MEDICATION TO SCHOOL WHEN NECESSARY.

Physician's Order for Medication

I have determined that the following medication must be taken by this student during school hours:

Drug: _____ Dosage: _____
Times Given: _____ BEFORE lunch/AFTER lunch (circle one)
Side Effects: _____

Intended effect of this medication: _____

Diagnosis: _____

Physician's signature: _____ Telephone: _____

Date: _____

Designee to Administer Medication

I authorize my child (name) _____ to have the drug, identified above by Dr. _____, administered during school hours, according to the said physician's orders. Parent to initial all that apply:

- _____ 1. My child is allowed to self-medicate.
- _____ 2. I will come to school to administer the medication.
- _____ 3. _____ (name of adult) is authorized by me to come to school and administer the medication to my child.

I, (parent/guardian name) _____ agree to indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication.

(Parent/guardian signature) _____ Date: _____

Parent/Guardian Consent for Student's Self-Administration of Asthma Medication

I authorize Troy C.C.S.D. 30-C, Will County, Illinois and its employees and agents, to allow my child or ward to possess and have discretionary use of his/her asthma medication (1) while at school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication. (105 ILCS 5/22-30.)

I, (parent/guardian name) _____ agree to indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication.

(Parent/guardian signature) _____ Date: _____

**Agreement of Student and Parent Regarding
Use of an Asthma Inhaler in School**

1. The student has demonstrated the correct use of the inhaler to school health personnel. (Initial by school health personnel) _____
2. The student agrees to **never** share the inhaler with another person.
3. The student agrees to report **each occasion of use** of the inhaler to the Medical Aide or to the school office.
4. The student agrees that if there is not marked improvement in his/her condition after two puffs of the inhaler, he/she will notify a teacher or other responsible adult who will take further action.

Student signature: _____

Parent signature: _____

Release of Medical Information

I, _____ give Troy Community Consolidated School District 30-C
Parent/Guardian's name
permission to contact _____ regarding my child's medical condition and/or
Physician's name
medication. This permission is good for one calendar year.

Parent/guardian signature